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1 PAB No. D86-119 (1987); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Skaalheim
2 v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

3
4 **II. RESPONDENT'S PRE-TRIAL MOTION TO QUASH SUBPOENAS
AND/OR TO EXCLUDE OR LIMIT WITNESSES**

5 2.1 On July 16, 2001, the Board granted Respondent's motion for a continuance of the October
6 4, 2001 hearing date on this appeal. The Board continued the hearing to February 19 and 20, 2002.
7 In its order, the Board directed the parties to complete discovery by January 18, 2002, and to
8 exchange witness and exhibit lists on or before February 11, 2002. The Board also directed the
9 parties to participate in a pre-hearing conference at 9 a.m. on February 12, 2002.

10
11 2.2 On February 11, 2002, Respondent faxed a copy of the agency's witness and exhibit lists to
12 Appellant's attorney and to the Board. Neither Respondent nor the Board received a copy of
13 Appellant's witness or exhibit lists.

14
15 2.3 On February 12, 2002, Respondent learned that Appellant had subpoenaed several Fircrest
16 School employees. Appellant did not provide copies of the subpoenas to Respondent's AAG or give
17 advance warning that the subpoenas would be served upon the employees. One of the subpoenas
18 commanded the production of documents at the hearing.

19
20 2.4 At 9 a.m. on February 12, 2002, the Board's Executive Secretary attempted to conduct the
21 pre-hearing conference as ordered by the Board. Appellant's attorney was not available. However,
22 Appellant's attorney telephoned the Executive Secretary at 9:50 a.m. and the conference was
23 conducted at that time. During the conference, Appellant's attorney indicated that he would be
24 calling 20 witnesses.

1 2.5 On February 13, 2002, Appellant's attorney faxed a copy of Appellant's witness list to
2 Respondent's AAG.

3
4 2.6 On February 15, 2002, Respondent filed a Pre-Trial Motion to Quash Subpoenas and/or to
5 Exclude or Limit Witnesses. The Board considered the motion at the outset of the hearing on
6 February 19, 2002.

7
8 2.7 In summary, Respondent argued that Appellant failed to follow the Board's procedural rules,
9 the civil rules regarding discovery, and the Board's order in this matter. Respondent asserted that
10 Appellant's witness list was filed late, and that 20 potential witnesses plus the Appellant was
11 extraordinary particularly when only five people had direct knowledge of the misconduct.
12 Respondent contended that 18 of Appellant's witnesses would be either non-relevant and/or
13 cumulative. Respondent asked that the subpoenas be quashed or that Appellant's proposed
14 witnesses be limited and that no witness be required to produce documents at the hearing.

15
16 2.8 In summary, Appellant argued the subpoenas were personally delivered to the witnesses and
17 that they should have provided copies to their supervisors or managers at Fircrest School.
18 Appellant further argued that Respondent failed to conduct discovery and therefore did not request
19 the names of the people Appellant felt would be witnesses at her hearing.

20
21 2.9 After considering the arguments of the parties, the Board orally granted the motion and
22 quashed Appellant's subpoenas. The Board found that Appellant failed to comply with the Board's
23 order and failed to serve subpoenas as required by the Board's rules. See WAC 358-30-120.
24 However, the Board did not preclude Appellant from calling witnesses who voluntarily appeared on
25 her behalf or from questioning the witnesses called by Respondent.

III. APPELLANT'S MOTION TO DISMISS

3.1 At the close of Respondent's case in chief, Appellant made an oral motion to dismiss. Appellant argued that this was a case of double discipline and that the Conduct Investigation Report (CIR) was untimely. Appellant argued that she had previously received a letter of reprimand regarding the use of time and asserts that Respondent cannot use this charge to support the matter at issue in this appeal. Appellant also argued that Fircrest management had knowledge of the alleged incidents of misconduct when they happened, yet failed to initiate the CIR within fourteen days of knowledge of the incidents.

3.2 Respondent argued that Appellant was disciplined for failing to respond to a nurse's call for help with a client, not for use of time. Therefore, Respondent contended that this is not a case of double discipline. Respondent further argued that pursuant to DSHS Policy 545, the CIR must be initiated within fourteen days following the date that a supervisor in the employee's chain of command becomes aware of the misconduct. The incidents that are the subject of this appeal occurred on August 21, 2000. Appellant's supervisor was made aware of the incidents on August 25, 2000. The CIR was issued to Appellant by certified mail on September 8, 2000. Therefore, Respondent argued that the CIR was timely.

3.3 The Board considered the arguments of the parties and denied the motion. Appellant received a prior letter of reprimand for use of time. There was no indication that the prior issues relating to her use of time were a basis for her reduction in salary, therefore, this was not a case of double discipline.

3.4 Prior discipline and reprimands may be taken into consideration for the purpose of determining the appropriateness of the disciplinary sanction, but not as the basis of the discipline itself. Jankowski v. Dep't of Social & Health Services, PAB No. D84-75 (1984).

1
2 3.5 Neither party provided a copy of DSHS Policy 545, which speaks to the CIR process. When
3 considering a motion to dismiss, all facts and reasonable inferences therefrom are to be determined
4 in favor of the nonmoving party. See Hall v. University of Washington, PAB No. 3863-V2 (1995).
5 Based on the arguments provided by the parties, we must conclude that in this case, the policy
6 required the CIR to be initiated within fourteen days following the date Appellant's supervisor first
7 became aware of the alleged misconduct. The CIR was initiated within this timeframe and
8 therefore, was timely.

10 **IV. FINDINGS OF FACT**

11 4.1 Appellant Linda Nachiem is a Registered Nurse (RN) 2 and permanent employee for
12 Respondent Department of Social and Health Services (DSHS) at Fircrest School. Appellant and
13 Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder,
14 Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on
15 January 2, 2001.

16
17 4.2 By letter dated December 11, 2000, Asha Singh, Superintendent of Fircrest School, notified
18 Appellant of her reduction in salary for neglect of duty, gross misconduct and willful violation of
19 published employing agency or department of personnel rules or regulations. Dr. Singh alleged
20 that on August 21, 2000, Appellant failed to carry out her responsibilities as the evening shift
21 charge nurse in the infirmary when she raised her voice and told Licensed Practical Nurse (LPN)
22 Paul Anderson that he was the only person responsible for client Gary's intake and when she did not
23 provide direction to Mr. Anderson in implementing Gary's plan of action. Dr. Singh also alleged
24 that later during the shift, when Mr. Anderson called for help with Gary after Gary became faint and
25 began to fall to the floor, Appellant failed to respond and failed to become involved in writing an
26 event report after the incident.

1
2 4.3 Appellant began employment as a nurse at Fircrest School in 1992. Appellant was aware of
3 her responsibility to be familiar with and abide by institution policies and procedures.
4

5 4.4 During the summer of 2000, Appellant's normal duty station was as a resource nurse
6 assigned to Program Area Team (PAT) N. On August 21, 2000, she was assigned as the charge
7 nurse in the infirmary. This was not her normal assignment, but she had previously worked in this
8 area.
9

10 4.5 As the charge nurse, Appellant was responsible for ensuring that patient care was properly
11 administered and that proper follow-up and documentation was completed. This included providing
12 guidance to Mr. Anderson, overseeing his work as the infirmary LPN during the shift and providing
13 him assistance as needed.
14

15 4.6 Appellant and Mr. Anderson had worked together on other occasions. However, they did
16 not get along. Mr. Anderson admittedly had work performance issues, but he believed that
17 Appellant was constantly yelling at him and providing him negative feedback. Appellant believed
18 Mr. Anderson needed constant guidance and monitoring, and she was concerned that the care he
19 provided put the clients at risk.
20

21 4.7 Client Gary was a patient in the infirmary on August 21, 2000. Gary was being resistive to
22 attempts to get him to eat or drink. As the LPN on duty, Mr. Anderson was assigned the task of
23 ensuring that Gary's intake of fluid and liquid was adequate as ordered by his physician. Although
24 Appellant was the charge nurse, she told Mr. Anderson that it was his responsibility to monitor
25 Gary's intake and to contact Gary's physician if necessary.
26

1 4.8 During the course of the evening, Mr. Anderson assisted Gary to the bathroom. When they
2 got into the bathroom, Mr. Anderson left the bathroom door open. Gary became faint and started to
3 slip to the floor. Mr. Anderson repeatedly called for help, but Appellant did not respond. Mr.
4 Anderson eased Gary to the floor.

5
6 4.9 While Mr. Anderson was assisting Gary to the bathroom, Appellant went to another
7 bathroom herself. When she returned, she sat on the couch in the TV viewing area. The TV is
8 located in an open area with no doors separating it from the hallway to the bathroom where Gary
9 and Mr. Anderson were when Gary began to faint.

10
11 4.10 RN 2 Nora Edwards was the acting RN 3 on the evening shift on August 21, 2000. The RN
12 3 is responsible for overseeing the ongoing care provided during the shift. Although Ms. Edwards
13 did not have supervisory responsibility over Appellant, she did have supervisory responsibility for
14 the infirmary. During the evening shift on August 21, 2000, Ms. Edwards went to check on the
15 infirmary, in part, because she was aware of the ongoing problems between Appellant and Mr.
16 Anderson.

17
18 4.11 Subsequent events are in dispute. However, we have carefully considered the testimony of
19 the witnesses and have viewed the infirmary area to understand the location of the parties, as well
20 as the location of RN 2 Judy Haakons who testified she was also present during the events. Based
21 on a preponderance of the credible testimony, we find as follows.

22
23 4.12 When Ms. Edwards entered the infirmary, she saw Appellant sitting on the couch and she
24 heard Mr. Anderson calling for help. She commented to Appellant that it sounded like Mr.
25 Anderson needed some help and she immediately went to the bathroom and helped Mr. Anderson
26 with Gary. Appellant remained sitting on the couch.

1
2 4.13 Ms. Haakons was in the infirmary taking care of a client. She was in a separate room with
3 the door partially closed. She did not observe or hear all of the events as they occurred. However,
4 she did hear Mr. Anderson's calls for help and she saw Ms. Edwards going down the hall toward the
5 bathroom.

6
7 4.14 After Mr. Anderson and Ms. Edwards took care of Gary, Ms. Edwards told Appellant that
8 an event report needed to be completed. Appellant did not respond and she did not assist with
9 writing the report.

10
11 4.15 Ms. Edwards was concerned about the incident in the infirmary and the lack of teamwork
12 she observed between Appellant and Mr. Anderson. On August 22, 2000, she told her supervisor,
13 RN 4 Ellie Draper, about her concerns. By memorandum dated August 23, 2000, she provided Ms.
14 Draper a written report of her concerns.

15
16 4.16 On August 25, 2000, Ms. Draper reported the incident and Ms. Edwards' concerns to
17 Appellant's supervisor, RN 4 Shirley Gilday. In addition, she gave Ms. Gilday a copy of Ms.
18 Edwards' memorandum. On August 28, 2000, Mr. Anderson gave Ms. Draper, his memorandum
19 describing the events of the August 21, 2000. Ms. Draper provided this document to Ms. Gilday.
20 On September 8, 2000, Ms. Gilday initiated a Conduct Investigation Report (CIR) against
21 Appellant.

22
23 4.17 Nursing Home Administrator Kathy Swenson was Appellant's second-line supervisor and
24 conducted the CIR administrative investigation. She met with Mr. Anderson, Ms. Edwards and
25 Appellant, reviewed Gary's records, reviewed agency's policies, and visited the infirmary. Ms.
26 Swenson determined that Mr. Anderson has a loud voice, that he was yelling for help, and that

1 Appellant should have heard him and responded. Ms. Swenson determined that Appellant
2 committed misconduct and failed to fulfill her duties as the charge nurse when she told Mr.
3 Anderson that he was solely responsible for Gary's food and fluid intake, when she failed to respond
4 to Mr. Anderson's calls for help, and when she failed to participate in completing the follow-up
5 event report. Ms. Swenson referred the CIR, including her administrative report, to Dr. Asha Singh.

6
7 4.18 Dr. Asha Singh is the Superintendent and the appointing authority for Fircrest School. After
8 reviewing the CIR information, and Appellant's personnel history, Dr. Singh determined that it was
9 necessary to impress upon Appellant the seriousness of the incident. Dr. Singh determined that
10 Appellant failed to carry out her responsibility to assure that Gary received the care he needed,
11 failed to provide guidance to Mr. Anderson, failed to respond to Mr. Anderson's calls for help with
12 Gary, and failed to assess Gary and assist in charting the incident.

13
14 4.19 The mission of Fircrest School is to maintain client health and safety. Fircrest School takes
15 client care and safety issues seriously. Dr. Singh determined that Appellant's misconduct was
16 contrary to the Fircrest mission and therefore, rose to the level of gross misconduct. Dr. Singh also
17 found that Appellant neglected her duty to carry out her charge nurse responsibilities and that she
18 willfully violated agency policies prohibiting abuse, neglect or negligent treatment of clients.

19
20 4.20 Dr. Singh concluded that a reduction in salary was sufficient to give Appellant a strong
21 message to change her behavior. Therefore, by letter dated December 11, 2000, Dr. Singh imposed
22 a two-month, two-step reduction in salary.

23
24 4.21 Fircrest School Procedure #1.A.01 sets forth the institution policy prohibiting abuse,
25 neglect, or negligent treatment of clients. The procedure states, in relevant part:

Policy

Abuse, neglect, or negligent treatment of clients is prohibited. This includes . . . failure to provide care. . . .

Definitions

. . . .

C. Neglect means conduct resulting in deprivation of care necessary to maintain minimum physical and mental health. This includes, but is not limited to, failing to provide training and support services which are necessary to maintain the person's health and safety.

D. Negligent Treatment means an act or omission which demonstrates a serious disregard of consequences of such magnitude as to constitute a clear danger to the person's health, welfare, and safety.

. . . .

I. Failure to provide care includes, but is not limited to: . . . failure to promptly respond to medical emergencies or request for medical treatment.

4.22 Fircrest School Procedure #1.B.19, Use of Duty Time, states, in relevant part:

I. Time is a costly resource. Employees are hired and are paid to perform functions which are necessary for efficient and effective operation of the facility, in fulfilling Fircrest School's MISSION.

. . . .

IV. It is not appropriate for an employee to be idle . . . while on duty. . . . Idleness on the job is in the category of "Neglect of Duty" (MSR 356-34-010) and will result in corrective and/or disciplinary action.

V. ARGUMENTS OF THE PARTIES

5.1 Respondent argues that as the charge nurse, Appellant was responsible to be attentive to what was going on in the infirmary and with the clients. Respondent argues that Ms. Haakons and Ms. Edwards heard Mr. Anderson's calls for help and contends that Appellant heard the calls but chose to ignore them. Respondent argues that regardless of whether Ms. Edwards was assisting Mr. Anderson, Appellant had a responsibility to at least investigate what was going on, to render assistance, and to oversee the process of completing the event report. Respondent argues that there was no reason why Appellant should not have responded to Mr. Anderson's calls for help and

1 suggests that Appellant consciously chose not to respond because she was tired of Mr. Anderson
2 asking for help. Respondent further argues that even if Appellant delegated responsibility for
3 Gary's intake to Mr. Anderson, as the charge nurse, she was ultimately responsible for Gary's intake
4 during the shift and to provide client care if Mr. Anderson was unable to do so. Respondent
5 contends that Appellant failed to further the idea of a team approach to client care. Respondent
6 asserts that Appellant's behavior was flagrant, adversely affected client care and was inconsistent
7 with her duties and responsibilities as the charge nurse. Respondent argues that the sanction was
8 appropriate.

9
10 5.2 Appellant argues that Mr. Anderson needed to be closely supervised which made her job
11 more difficult and that as a member of the infirmity client care team, Mr. Anderson needed to learn
12 to do his job. Appellant contends that Gary's life and safety were not at issue, otherwise, Ms.
13 Edwards would have asked for assistance and that because both Mr. Anderson and Ms. Edwards
14 were caring for the client, there was no need for her to respond. Appellant further contends that
15 since she did not view the incident, she was not responsible for filing out the event report.
16 Appellant asserts that she is very conscientious about client safety and that having this discipline in
17 her record puts a black mark on her reputation and is damaging to her psychological self. Appellant
18 argues that she did not hear what was happening, that she did not ignore Mr. Anderson's calls for
19 help, and that she did not willfully or deliberately commit misconduct.

20 **VI. CONCLUSIONS OF LAW**

21 6.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter
22 herein.

23
24 6.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting
25 the charges upon which the action was initiated by proving by a preponderance of the credible
26

1 evidence that Appellant committed the offenses set forth in the disciplinary letter and that the
2 sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of
3 Corrections, PAB No. D82-084 (1983).

4
5 6.3 Neglect of duty is established when it is shown that an employee has a duty to his or her
6 employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't
7 of Social & Health Services, PAB No. D86-119 (1987).

8
9 6.4 Willful violation of published employing agency or institution or Personnel Resources
10 Board rules or regulations is established by facts showing the existence and publication of the rules
11 or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the
12 rules or regulations. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

13
14 6.5 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to
15 carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

16
17 6.6 Respondent has met its burden of proof that during the evening shift on August 21, 2000,
18 Appellant neglected her duty and failed to fulfill the duties of a charge nurse. Respondent has
19 proven that Appellant failed to provide guidance to Mr. Anderson regarding Gary's intake, failed to
20 respond to Mr. Anderson's calls for help, and failed to assess Gary or ensure that the event was
21 properly documented and reported. Respondent proved that Appellant's actions were a violation of
22 institution policies and procedures and rose to the level of gross misconduct. Appellant's actions
23 and inactions were flagrant, deliberate and contrary to the Fircrest mission of providing for the
24 health and safety of clients.

1 6.7 Under the totality of the proven facts and circumstances presented here, Respondent has met
2 its burden of proving the charges in the disciplinary letter. Furthermore, Respondent has
3 established that the disciplinary sanction of a reduction in salary is appropriate. Therefore, the
4 appeal should be denied.

5
6 **VII. ORDER**

7 NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Linda Nachiem is denied.

8 DATED this _____ day of _____, 2002.

9
10 WASHINGTON STATE PERSONNEL APPEALS BOARD

11 _____
12 Walter T. Hubbard, Chair

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14 _____
15 Gerald L. Morgen, Vice Chair
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